medical review and advisory board

OF THE CALIFORNIA MEDICAL ASSOCIATION

The Development of the Board

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THE GROWING PROBLEM of non-meritorious medical malpractice actions against physicians in California, together with a rapidly increasing premium rate for insurance coverage for judgments against physicians and the high incidence of such claims in California, led to the appointment of an *ad hoc* Committee on Malpractice Insurance by the Executive Committee of the California Medical Association in August, 1954. This committee consisted of Joseph F. Sadusk, Jr., M.D., Oakland, chairman; Wilbur Bailey, M.D., Los Angeles, vice-chairman; David O. Harrington, M.D., San Francisco, secretary, and members as follows: H. I. Burtness, M.D., Santa Barbara; Albert Currlin, M.D., Milpitas; John Ellis, M.D., Taft; Paul W. Frame, Jr., M.D., Sacramento; Verne G. Ghormley, M.D., Fresno; Carl M. Hadley, M.D., San Bernardino; J. J. Heffernan, M.D., Stockton; Joseph J. O'Hara, M.D., San Diego; William F. Quinn, M.D., Los Angeles; Denver D. Roos, M.D., Corona; Bernard Silber, M.D., Redwood City; and John Wood, M.D., Anaheim. Mr. Howard Hassard was appointed legal counsel and Mr. Rollen Waterson administrative consultant.

The directive of this committee was broad in scope. Instructions were given to make a thorough review of the medical malpractice claim problem as it then existed in California, and elsewhere as time and conditions permitted. The committee was asked to review the present coverage by insurance carriers in this field throughout the state and, finally, to present concrete recommendations to the C.M.A. Council for the future.

In October, 1954, the committee, which was representative of opinions throughout the entire state, quickly reviewed the problem. An executive group of the committee was appointed and instructed to prepare in detail a survey of medical malpractice insurance coverage in California, taking into special consideration the group programs, the extent and type of coverage, and whether or not the coverages at present given were acceptable to the physicians. At a later date, the chairman was instructed to review and report to the committee on the function and status of the group program in New York State. That program is the largest in the United States, covering approximately 14,000 physicians.

At a later meeting, the committee reviewed in considerable detail medical malpractice insurance coverage now available in California. There appeared to be basically two group programs: One was the northern California program, which was followed in an area bounded on the south by a line drawn north of Bakersfield and on the north by the Oregon border. It comprised some 20-odd counties. The other was the Los Angeles County Medical Association program. In the northern California program, one carrier, the American Mutual Liability Insurance Company of Boston, covered the entire area. In Los Angeles County at that time there were three approved carriers. Some nine to ten thousand members of the California Medical Association came under a group program for medical malpractice insurance. The remaining members in the state, particularly in southern California, were covered as individuals by a number of carriers, principally the so-called National Bureau Companies (Hartford, Travelers and Aetna).

The situation with regard to coverage was found not to be good. There were a variety of policies with different exclusion clauses; some of them were quite unsatisfactory. In addition, some of the carriers, particularly some of those which covered physicians individually, required so-called "package deals": The physician had to buy all types of insurance from the company in order to obtain malpractice insurance. Instances were reported of physicians of known integrity and professional

ability being unable to obtain malpractice insurance coverage at any price. The premiums varied greatly. Most insurance carriers had progressed to the point where the difference in hazard between surgical and nonsurgical coverages was well recognized, resulting in a differential rate. It was found that premiums for the basic $5,000/15,000 coverage ranged anywhere from $50 a year for nonsurgical work to as high as $282 for an anesthesiologist desiring coverage for caudal and spinal anesthesia. For surgeons in certain so-called hazardous fields such as cosmetic plastic surgery, the premium for the basic $5,000/15,000 was as high as $289 in one area. In another area premiums for an anesthesiologist exceeded $800 a year for $100/300,000 coverage.

The acceptance of the insurance policies by the insured and the attitude of the physician toward the carrier varied greatly within the state. In some areas, physicians were well satisfied, and claims adjustments were considered excellent; in others the handling of claims by the carriers was reported to be unsatisfactory. In some instances the insurance companies were dissatisfied because of lack of cooperation by the physician.

The committee learned that premium rates had been increasing yearly not only in California but elsewhere in the United States and also in Canada. Premiums were found to have trebled since 1946 in some areas; in some they had quadrupled.

The committee came to the opinion that the factors leading to high premium rates in California were:

1. Inflation, necessitating higher payment for claims, judgments and defense.

2. The increasing tendency of the public to seek financial remuneration for imaginary or real damage, and for failure in diagnosis and treatment.

3. The increasing tendency of juries to award high judgments.

4. Unfavorable articles in lay magazines dealing with alleged malpractice, fee splitting, etc., and even the favorable articles which led the layman to believe that a less than perfect result is evidence of negligence.

5. Fee complaint problems which led to claims or suits filed to evade payment to the physician for his services.

6. Inherent hazards in certain fields of medicine, particularly in the surgical field.

Thanks to certain of the insurance carriers providing malpractice insurance coverage in California, data were obtained on premiums collected and losses paid out during the years 1946 through 1951. These data were carefully analyzed by the committee. It was found that in no instance in the state was there evidence that companies were making a profit on medical malpractice insurance; indeed, all companies showed a loss despite the rapid rise in premiums. The committee noted that this was true not only in California but in some other states. In the northern California program, the deficit was running approximately one million dollars a year; in New York State, it was found to be a matter of record that the group program was running a deficit of over three million dollars.

The chairman reported to the committee on his survey of the New York State program which had begun operations in 1921. This program was set up as a division of the New York State Medical Society. A committee, termed the Malpractice Insurance and Defense Board (consisting of a physician chairman, a physician vice-chairman, and five physician members) regulated the program with the assistance of a full-time executive secretary and a legal counselor. Approximately 14,000 physicians held insurance certificates in this program. The Board was responsible for negotiating premiums, for setting of broad policy for the defense of cases, for monitoring an educational and prevention program. It had disciplinary powers with respect to those physicians who committed repeated and flagrant acts of malpractice.

In April, 1955, as a result of careful review of medical malpractice insurance in the State of California, New York and elsewhere, the California Medical Association's *ad hoc* Committee on Malpractice Insurance recommended the following to the Council of the California Medical Association:

1. The creation of a group state program in California, embodying the good principles of the New York State program and the good principles of the northern California program at county level. It was recommended that there be a committee offering advisory services at state level, with actual functioning services to be provided at county level. Each county would have its own authority to select an insurance carrier and to regulate its own program.

2. The organization, at the state level, of a Medical Review and Advisory Board. This Board would be a component division of the California Medical Association and subject to the Council of the C.M.A. The Board would be served by a part-time executive secretary. This board was to consist of a physician chairman and approximately nine physician members. Also assigned to the Board would be legal counsel and an actuarial consultant. The executive secretary would carry on the day-to-day functioning of the Board.

3. Assignment to the Board of the following responsibilities: (a) assisting the counties with the

negotiation of policies and premiums; (b) setting of broad policy for the handling of suits within the state; (c) reviewing all anticipated appeals of lawsuits and approving or disapproving transfer of such suits to the appellate courts; (d) continuously receiving and analyzing data from the county programs on cost, distribution, type and causes of malpractice cases; (e) developing and monitoring an educational and prevention program; (f) continuously receiving the malpractice records of physicians and making a review and advisory service available on request to county committees on the acceptance of physicians in group programs, the modification of their coverage, or their rejection from a program.

It was recommended that the *ad hoc* Committee on Medical Malpractice Insurance be dismissed and that the Medical Review and Advisory Board, as noted above, be set up permanently to carry on a state program.

As a result, in May of 1955 the House of Delegates of the C.M.A. approved the council's recommendation for the setting up of a Medical Review and Advisory Board as defined above. A budget of $17,000 for the first year's operations was likewise approved. The board was set up as follows:

	Term expires
JOSEPH F. SADUSK, JR., M.D., Chairman, Oakland	1958
WILBUR BAILEY, M.D., Vice-Chairman, Los Angeles	1956
HOWARD W. BOSWORTH, M.D., Los Angeles	1956
H. I. BURTNESS, M.D., Santa Barbara	1956
PAUL W. FRAME, JR., M.D., Sacramento	1958
VERNE G. GHORMLEY, M.D., Fresno	1956
CARL M. HADLEY, M.D., San Bernardino	1958
JOSEPH J. O'HARA, M.D., San Diego	1957
REES B. REES, M.D., San Francisco	1957
BERNARD SILBER, M.D., Redwood City	1957

Legal Counselor: HOWARD HASSARD

Actuarial Consultant: JOSEPH LINDER (Wolfe, Corcoran and Linder)

Executive Secretary: ROLLEN WATERSON

The Medical Review and Advisory Board has had two meetings. It has received a report of Mr. Joseph Linder, the consulting actuary, and has reviewed and edited the specifications as prepared by Mr. Howard Hassard, the legal counselor. The specifications (which are presented in full at the end of this article) provide in very broad terms for the following:

1. A state-wide coordinated medical malpractice program administered and directed by the county medical societies at county level with a "safety" (prevention) program at the same level, and with advisory services offered at state level by the Medical Review and Advisory Board.

2. Complete financial and professional loss data to be collected for the state by the Medical Review and Advisory Board as the basis for a realistic annual recalculation of premium.

3. Specific data to be available for statistical analysis of losses by type of practice and by type of loss.

4. Reserves set aside by the carrier for each claim to be a matter of record in the Medical Review and Advisory Board files and the record to be available to each county medical society.

5. The cost of administration and carrying through of the safety program at county level to be provided for out of premiums.

6. Medical Review and Advisory Board expenses to be financed through the C.M.A. state budget.

In addition the Board voted to request the editor of CALIFORNIA MEDICINE to have a more or less regularly recurring section in that journal for the Medical Review and Advisory Board. The purpose of this section will be to educate and inform physicians of the status of malpractice problems within the state as the program develops.

In order to expedite the collection of statistical data, the California Medical Association will ask all carriers of malpractice insurance in California to cooperate by supplying data on losses to the Medical Review and Advisory Board from January 1, 1955, onward.

These recommendations, along with the final draft of the specifications for a state-wide malpractice program, were presented to the C.M.A. Council on August 28, 1955, and approved by that body on the same date. Copies of the specifications and recommendations have been mailed to the constituent county medical societies of the California Medical Association, and each county medical society will be provided with copies for each member if it wishes to mail out such copies.

It is important to reemphasize certain of the basic policies of the Medical Review and Advisory Board. First, it should be stressed this is a truly *advisory* board. Insurance and policies will *not* be sold by the Board. The program is to be handled entirely at the level of each county or in any combination of county societies as they may wish. The expenses for the Medical Review and Advisory Board will not come out of the physician's premium dollar. Such expense as is necessary to finance the functions of the Board at state level will come from the budget of the California Medical Association. These expenses will be published yearly in CALIFORNIA MEDICINE for the information of all physicians, and it has been recommended to each county medical society that the expenses for the administration of the programs at county level be likewise published in the county's medical bulletin. Each physician

then will be able to determine how much of his premium dollar is being paid out for the administration of the program, the support of the county Medical Review Committee's work in analyzing each malpractice claim, and the cost of the safety or prevention program.

Recommendations and Specifications to County Medical Societies for a Group Malpractice Insurance and Prevention Program*

The following set of specifications has been adopted by the Medical Review and Advisory Board of the California Medical Association as a guide to county medical societies in the establishment and maintenance of group malpractice insurance and prevention programs. The specifications are for the type of program recommended by the Medical Review and Advisory Board and the Board will fully cooperate with programs that meet them.

EACH SPECIFICATION IS INTENDED TO STATE A GENERAL PRINCIPLE AND NOT AN INVIOLABLE RULE. Certain minor variations to take into account local conditions may be necessary and will be recognized by the Medical Review and Advisory Board.

1. *Nature of Program:*

A county society malpractice insurance and prevention program should include:

A long-term contract with an insurance carrier (minimum 5 years—10 recommended).

The establishment and active operation by the county medical society of a Medical Review Committee responsible for

(a) Investigation, review and recommendations regarding the medical aspects of each malpractice claim or suit arising in the county, such investigation and review to be strictly on a merit basis with the interests of both patient and physician accorded equal protection and the committee's recommendations to be available only to it, the group insurance carrier, defense counsel, and the physician against whom claim or suit has been made, and

(b) Carrying on a continuing educational program within the Society regarding the legal responsibilities of physicians, the causes of malpractice claims and suits, and the steps that may be taken to avoid them.

2. *Selection of Insurance Carrier:*

An insurance carrier should be selected on a merit basis, but only those carriers which meet the following criteria should be given consideration:

(a) The carrier should be licensed by the California Insurance Commissioner, or permitted by California law to write contracts in this state as a surplus line insuror,

(b) It is desirable that paid-in capital and unassigned surplus of the carrier should be at least ten times the aggregate annual gross premiums paid by all physicians in the Society for the immediately preceding year or $5,000,000.00, whichever is greater,

(c) It is desirable that such capital and unassigned surplus should be held by the carrier in investments in the United States,

(d) Carriers with previous experience in the group malpractice field should be preferred over those with no experience at all.

3. *Type of Contract:*

The contract should contain a broad definition of the acts or omissions insured against, e.g. all claimed malpractice, errors or mistakes, breach of implied contract, assault, battery, slander, etc.

Settlements without the written consent of the insured physician, or the Society should be prohibited.

There should be no exclusions as to the obligation of the carrier to defend, and the only exclusions from the carrier's obligation to indemnify should be criminal acts or acts undertaken by the physician while under the influence of narcotics or alcohol.

Certificates issued under the master contract should not be subject to cancellation except as hereinafter specified.

4. *Cancellation:*

The master contract should permit outstanding certificates to be cancelled only with the mutual consent of the Society (acting through its committee, or, upon request, the California Medical Association's Medical Review and Advisory Board) and the carrier. If the Society so desires, the contract should provide that in the event of recommended cancellation, the physician involved, the Society or the insuror may appeal to the C.M.A. Medical Review and Advisory Board, whose decision shall be final. The carrier should be obligated to issue renewal certificates to all Society members who have paid the appropriate premium and whose certificates have not been cancelled under the above procedure.

5. *Limits of Liability (Amount of Coverage):*

Limits of liability should be available in an amount of not less than $100,000 per person and $300,000 per contract year. The minimum coverage written should be not less than $25,000 per person and $75,000 per contract year for practicing physicians and $5,000/$15,000 for physicians engaged in full time postgraduate education (generally known as resident

*Approved by the Council of the California Medical Association, August 28, 1955. Amended November 11, 1955. Approved by C.M.A. Council, November 12, 1955.

house officers). Each physician should be permitted to select coverage limits in the standard brackets of $25,000/$75,000, $50,000/$150,000, $75,000/$225,-000, $100,000/$300,000.

6. *Premium Rates:*

Rates should be adjusted annually, should be in effect from September 1 to August 31 and should be based on all pertinent experience data up to December 31 of the preceding year. Rates may vary by county or by rating classes within a county, each rating class consisting of one or more types of practice.

At least six months prior to the commencement of each contract year, the insurance carrier should submit to the Society its proposed rate structure for the ensuing year and should also submit to the Society all data and statistics on which its proposed rates are based. At least four months prior to the commencement of the contract year, the Medical Review and Advisory Board will, if the Society so desires, assist in the negotiation of the proposed new rates.

7. *Defense of Claims and Suits:*

(a) The carrier should satisfy the Society that it has an experienced and adequate investigation staff.

(b) Defense counsel should be mutually selected by the carrier and the Society after consultation with the Medical Review and Advisory Board of the C.M.A.

(c) The carrier should agree that, upon request of the Society, its investigation system and general handling of claims and suits shall be subject at all times to inspection and review by a designated consultant representing the C.M.A.'s Medical Review and Advisory Board.

(d) The carrier and the Society should agree that final decision as to the taking of an appeal in any case in which an adverse final judgment has been rendered should be made after consultation with legal counsel for the C.M.A.'s Medical Review and Advisory Board.

8. *Records and Statistics:*

(a) The carrier and the Society should agree that within a reasonable time after the close of each month, there shall be furnished to the Society for forwarding to the Medical Review and Advisory Board summary information on exposure and premiums for each county—divided by type of practice.

At the time of the establishment of a reserve on each claim there should also be furnished to the Society for forwarding to the Medical Review and Advisory Board a synopsis of the case including the amount of the reserve. Also, every change in each such reserve (including the amount finally paid, if any) should be reported to the Society and to the Board.

(b) The carrier should agree that in establishing a reserve or in making a reserve change for each incident, claim or suit, each such reserve or reserve change shall be set up only after consultation between legal counsel for the Society and the carrier.

(c) All data compiled by the C.M.A.'s Medical Review and Advisory Board from the information so furnished will be at all times available to the Society and the carrier.

9. *Enrollment:*

(a) Eligibility to participate in the program should be restricted to members of the Society who are approved by the Society for insurance. If the Society so desires, the contract should provide that in the event the Society refuses to approve an applicant, he may appeal to the C.M.A. Medical Review and Advisory Board, whose decision shall be final.

(b) Individual certificates issued under the master contract should be for full twelve months intervals, without a common expiration date.

10. *Disputes:*

The carrier and Society may agree that in the event of difference of opinion between them respecting such matters as cancellation of an individual physician's coverage, eligibility for enrollment, application of the experience rating formula to premiums, interpretation of contract provisions, etc., all relevant facts concerned may be submitted to the C.M.A.'s Medical Review and Advisory Board, and if so submitted its decision shall be final and binding on the carrier and the Society.

11. *Fund for Collection Costs and Safety Program:*

The Society and insuror should agree that a fixed sum per certificate in force per year should be paid by the insuror into a separate trust fund set up and managed by the Society for the purpose of a continuing malpractice safety program to reduce causes of malpractice claims and to defray routine premium collection and similar costs. Such Fund should be used for these purposes only and should be subject to audit by the C.M.A. Medical Review and Advisory Board to verify that such Fund has been expended within these purposes.